Pre-Transfer Screening and Treatment of Lice, Scabies, Bedbugs or Other Infestations

Client Name: ____

Date and Time of Assessment ***(MUST BE < 24 HOURS PRIOR TO TRANSFER)*****:**

Date: ____________________ **Time:** ______________________

☐ **Hair/Scalp checked**

☐ **Body checked**

☐ **Clothing and Belongings checked**

☐ **Bedding checked**

☐ **The patient is free of lice/scabies/bedbugs/other infestation**

☐ **The patient had confirmed infestation during hospital stay**

Type of infestation: ____

Date infestation noted: ____

Medication used to treat: ____

Date patient treated: ____

Date clothing/belongings treated: ______________________________________

Method of treating clothing/belongings: ____________________________________

COMMENTS: ____

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UNIT: ____

STAFF SIGNATURE: ____

DATE: ____